1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01370

CERTIFICATE OF DEATH

01353

Reg. Dist. No.

M

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 650 Washington St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland Md
d. STREET ADDRESS: 650 Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jessie — Middle: (Sahwal) — Last: Arendes

4. DATE OF DEATH: Month: Feb. — Day: 23 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 13 1883

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U. S. A

I

13. FATHER'S NAME: Henry C Schwab

14. MOTHER'S MAIDEN NAME: Mary Van Dusen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mr. Philip J. Arendes Cumb. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis, Rt., with L. hemiplegia
DUE TO (b): Hypertension and A. S. Vascular Disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 28 Dec. 1955 & ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 28 Dec., 1955, to 23 Feb., 1962, that I last saw the deceased alive on 22 Feb., 1962, and that death occurred at 12 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Alfred Van Ormer M.D.
ADDRESS (Street, city or town, state): Medical Bldg., 122 S. Centre St.
DATE SIGNED: 2/26/62

PHYSICIAN'S NAME (Type): W. Alfred Van Ormer, M. D. — Cumberland, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/26/62
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.
22d. LOCATION (City, town, or county) (State): Cumberland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lewis Stein Inc
ADDRESS: Cumb. Md

24a. REC'D BY REGISTRAR DATE: FEB 28 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

01354

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01371

CERTIFICATE OF DEATH

Item 9 Film-G308 3/5/62 jwk

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RT 1 BOX223 FROSTBURG, MD.
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: JENNIE — Middle: B. — Last: BARBER

4. DATE OF DEATH: Month: 2/20/ — Day — Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: NOV. 28, 1887

9. AGE (In years last birthday): 75 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: DECEASED

14. MOTHER'S MAIDEN NAME: DECEASED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: CHART

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)	Starvation	3 mo
DUE TO (b)	Intestines to much + lungs	6 mo
DUE TO (c)	Carcenoma Sq. Cell Left Alveolar Mucosa	2 years

144X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 6, 1961 to Feb 20, 1962 that (I) (we) last saw the deceased alive on Feb 20 1962 and that death occured at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. Dhett Rathbone M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS: Medical Bldg, Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/23/1962

23c. NAME OF CEMETERY OR CREMATORY: Eckhart Cemetery

23d. LOCATION (City, town or county) (State): Eckhart , Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn

ADDRESS: Lonaconing, MD.

25a. REC'D BY REGISTRAR DATE: FEB 26 '62

25b. REGISTRAR'S SIGNATURE: Clinton S. Frana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01372 01355

CERTIFICATE OF DEATH

Item 9 Film G307 2/15/62 ink

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 6 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
   d. STREET ADDRESS: 1 521 HILL TOP DRIVE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First PHILLIP — Middle — Last BARKMAN

4. **DATE OF DEATH**: Month FEBRUARY — Day 7 — Year 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-19-1890 / 1890 71

9. AGE (In years last birthday): 69 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED -Supt.

10b. KIND OF BUSINESS OR INDUSTRY: Steel Industry

11. BIRTHPLACE (County & State, or foreign country): MARYLAND -FLINTSTONE

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BENJAMIN F. BARKMAN

14. MOTHER'S MAIDEN NAME: DOROTHY HERBST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-05-9505

17. INFORMANT: Address MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 Coronary Artery Disease - for advanced
DUE TO (b): Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Genital Polyp - Removed.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 10-24 1961 to 2-7-1962, that (I) ~~(we)~~ last saw the deceased alive on 2-6-1962, and that death occured at 4:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: W. F. Williams M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/7/62

22c. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22d. ADDRESS: 122 S. CENTRE STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.10,1962

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

23d. LOCATION (City, town or county) (State): Cumberland,Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 14 '62

25b. REGISTRAR'S SIGNATURE: Curtis L. Kinna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01373 **CERTIFICATE OF DEATH** 04856

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 24 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
   d. STREET ADDRESS: 420 LOUISIANA AVE.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CHARLES — Middle A. — Last BARRINGER

4. **DATE OF DEATH**: Month FEB. — Day 5, — Year 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-13-1887

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Printer

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (County & State, or foreign country): NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: REDWINE BARRINGER

14. MOTHER'S MAIDEN NAME: LELIA C. NASH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): War I

16. SOCIAL SECURITY NO.: 214-05-7258

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis, Marked — INTERVAL BETWEEN ONSET AND DEATH: 8 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c): Generalized Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 1-12- 8:30 19 62 P.M. to 2-5- 19 62, that (I) ~~(we)~~ last saw the deceased alive on 2-5- 19 62 and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: W. F. Williams M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-7-62

22c. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS

22d. ADDRESS: 122 S. CENTREST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Feb.8,1962 — 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park — 23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 13 '62 — 25b. REGISTRAR'S SIGNATURE: Carlton L. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01374 Item 2 film G307 2/19/62 jwb 01357

TO HOSPITALS OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
CITY OR TOWN: CUMBERLAND
MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): —
c. LENGTH OF STAY IN 1b: 31 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL MEMORIAL & WARWICK AVE.

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: ~~MARYLAND~~ Pa.
b. COUNTY: BEDFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD. 75x-3
d. STREET ADDRESS: RT#3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First ALPHA Middle PEARL Last BENNETT
4. DATE OF DEATH: Month FEB Day 11 Year 1962

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 8-23-1905
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress for an Interior Decorator
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): BEANS COVE, PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ALBERT SOMERLOTT
14. MOTHER'S MAIDEN NAME: BLANCHE ELLIOTT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 213-22-2718
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 163X Carcinoma of lung &
DUE TO (b): metastases to spine, lungs,
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov 19 62 to 2/11 19 62, that (I) (we) last saw the deceased alive on 2/11 19 62 and that death occured at 9:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/13/62
22c. PHYSICIAN'S NAME (Type): DR. S.G. WEISMAN
22d. ADDRESS: 59 GREENE ST., CUMBERLAND MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/14/62
23c. NAME OF CEMETERY OR CREMATORY: Bethel Cemetery
23d. LOCATION (City, town or county) (State): Near Centerville Penna

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ruth E. Silcox Cumberland Maryland
25a. REC'D BY REGISTRAR DATE FEB 15 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01375

CERTIFICATE OF DEATH

01358

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 23 W. ROBERTS ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HOMER — Middle: GUY — Last: BICE

4. DATE OF DEATH: Month: FEBRUARY — Day: 6, — Year: 19 62

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED ☒	10-23-1900	61 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist Helper Railroad
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): XXXXX, Omaha, Neb.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: LEROY BICE
14. MOTHER'S MAIDEN NAME: DELLA ROY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes
(If yes give war or dates of service): War II
16. SOCIAL SECURITY NO.: 705-10-3646
17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Uremia Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Coronary Artery Disease Severe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/1/62 19 to 2/6/62 19, that (I) ~~(was)~~ last saw the deceased alive on 2/6/62 19, and that death occured at 1:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: R. J. Williams M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/7/62
22c. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS
22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Feb.9,1962	Hyndman Cemetery	Hyndman, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarrelli, Cumberland, Md.	FEB 14 '62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01376

CERTIFICATE OF DEATH

01359

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pa... may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely ... in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. P... es 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: ALLEGANY; b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND; c. LENGTH OF STAY IN 1b: 26 DAYS; d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.,; MARYLAND

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — a. STATE: WEST VIRGINIA; b. COUNTY: KKK MINERAL; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROUTE # 1 RIDGELEY WEST VIRGINIA; d. STREET ADDRESS; e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: LEONARD; Middle: OLIVER; Last: BOONE

4. **DATE OF DEATH**: Month: FEBRUARY; Day: 25; Year: 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 10, 1905

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist Helper

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R Rwy.

11. BIRTHPLACE (County & State, or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: JOHN I. BOONE

14. MOTHER'S MAIDEN NAME: DAVY, MARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 705-05-5327

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 163X — Carcinoma of Lung, with Metastasis — Tp

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from.. June 61 19..., to... Feb 62, 19..., that (I) (we) last saw the deceased alive on... Feb 25 ...19 62 and that death occured at 9:05 P.M., from the causes and on the date stated above

22a. SIGNATURE: O. Himmelwright M.D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/27/62

22c. PHYSICIAN'S NAME (Type): DR. OVERTON HIMMELWRIGHT

22d. ADDRESS: 133 VIRGINIA AVENUE, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/28/62

23c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery

23d. LOCATION (City, town or county) (State): Near Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Charles L. George

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: MAR 1 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Kenny

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01377 — 01860

CERTIFICATE OF DEATH

Item 9 Film G307 2/15/62 iwk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 52 CUMBERLAND
   d. STREET ADDRESS: 7 Euclid Place — a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First DAVID — Middle LAWRENCE — Last BRAILER

4. **DATE OF DEATH**: Month 2 — Day 8 — Year 1962

5. SEX: MALE — 6. COLOR OR RACE: WHITE — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 9/11/09 — 9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker — 10b. KIND OF BUSINESS OR INDUSTRY: Baking Co. — 11. BIRTHPLACE (County & State, or foreign country): MARYLAND — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Augustine BRAILER — 14. MOTHER'S MAIDEN NAME: MARY ANN PENLEBERRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown): Yes — (If yes, give war or dates of service): WWII — 16. SOCIAL SECURITY NO.: — 17. INFORMANT: CHART — Address:

18 **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): 581.6 — Portal Cirhosis & hepatic failure — 18 mos.
- DUE TO (b):
- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

Hypostatic pneumonia, Cardiac decompensation, Epilepsy

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 1960 to 2-8, 1962, that (I) (we) last saw the deceased alive on 2-8, 1962, and that death occured at 9:35 AM from the causes and on the date stated above.

22a. SIGNATURE: William R James M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/10/62

22c. PHYSICIAN'S NAME (Type): DR. JAMES — 22d. ADDRESS: 441 N CENTRE STREET

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/12/62 — 23c. NAME OF CEMETERY OR CREMATORY: St. Patricks Cem. — FEB 13 '62 — 23d. LOCATION (City, town or county) (State): Mt. Savage Md

24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc. — ADDRESS: Cumb. Md — 25a. REC'D BY REGISTRAR DATE FEB 13 '62 — 25b. REGISTRAR'S SIGNATURE

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01378 01361

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 115 So. Allegany St.,

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Cumberland,
d. STREET ADDRESS: 115 So. Allegany St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gertrude; Middle: Hazel; Last: Carder

4. DATE OF DEATH: Month: Feb. Day: 17, Year: 19 62

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 14, 1902
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR — Months: Days:
IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager
10b. KIND OF BUSINESS OR INDUSTRY: Apt. Bldg.
11. BIRTHPLACE (County & State, or foreign country): Halltown, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Charles W. Brown
14. MOTHER'S MAIDEN NAME: Fannie Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Morris L. Barnes
Address: 115 So. Allegany St Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 420.1 Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): Far advanced Coronary artery disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY — Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 1-18-19 67 to 2-17-19 67 that (I) ~~(we) last~~ saw the deceased alive on 2-9-19 67 and that death occured at 11:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. F. Williams M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/19/62
22c. PHYSICIAN'S NAME (Type): W. F. Williams M.D.
22d. ADDRESS: 122 So. Centre St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/20/62
23c. NAME OF CEMETERY OR CREMATORY: Grace Episcopal Cem.
23d. LOCATION (City, town or county) (State): Elkridge, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George
ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 21 '62
25b. REGISTRAR'S SIGNATURE: with a Stamp

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01379

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01362

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D. O. A. Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cresaptown,
d. STREET ADDRESS: 101 Brant Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OSCAR; Middle HENRY; Last CECIL

4. DATE OF DEATH: Month Feb. Day 24, Year 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 30, 1903

9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager,

10b. KIND OF BUSINESS OR INDUSTRY: Packing House

11. BIRTHPLACE (State or foreign country): Cresaptown, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John W. Cecil

14. MOTHER'S MAIDEN NAME: Susan Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No,

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Ada R. Cecil Address: 101 Brant Rd. Cresap- Md. town,

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO (b): CORONARY SCLEROSIS — -----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m., Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic M D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: February 24, 1962

Address (Street, city, town, or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/27/62

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

22d. LOCATION (City, town, or country) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR: Charles L. George ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: FEB 28 '62

24b. REGISTRAR'S SIGNATURE: Catherine L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any data necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME 5M 9 60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01380

CERTIFICATE OF DEATH

01363
Reg. Dist. No.

(M)

(I)

1X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Alle ny MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: aryland b. COUNTY: All y

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland

c. LENGTH OF STAY IN 1b: 1yr;1mo.,3das

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sylvan Retreat

d. STREET ADDRESS: 400 Gr d Ave ue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Edna Middle: Last: Ch dwick

4. DATE OF DEATH Month: Feb. Day: 23 Year: 19 62

5. SEX: Fe male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 19, 1880

9. AGE (In years last birthday): 81 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Department Store

11. BIRTHPLACE (State or foreign country): Keyser W.Va.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Jeremiah Chadwick

14. MOTHER'S MAIDEN NAME: Barbara Roades

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Floyd Chadwick Address: Wyckoff, N.J.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

INTERVAL BETWEEN ONSET AND DEATH

1 7 0 X

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) [illegible]

DUE TO (b) [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 1711 [illegible]

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 19 61, to Feb. 23, 19 62, that I last saw the deceased alive on Feb. 23, 19 62, and that death occurred at 2:35 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [illegible] M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED: 2/24/62

PHYSICIAN'S NAME (Type): L. L. athews, .D. 4 Greene Street, C lerl d, d.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-26-62

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cem.

22d. LOCATION (City, town, or county) (State): Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James Scarpelli ADDRESS: Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: FEB 27 '62

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01381 **CERTIFICATE OF DEATH** 01364

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Midland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Paradise Street

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Midland
d. STREET ADDRESS: 1 Paradise Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Isabella Middle: Ross Last: Clise

4. **DATE OF DEATH**: Month: 2/1/1962 Day: Year: 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/11/1887

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Salem Ross

14. MOTHER'S MAIDEN NAME: Mary Ellen Dye

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Thomas F. Clise (Husband) Address: Midland, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

DUE TO (b): Arteriosclerosis + Hypertension — years

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 321X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 27, 1956 to Feb. 1, 1962 that (I) (we) last saw the deceased alive on Jan. 30, 1962, and that death occured at 9 A.M. from the causes and on the date stated above.

22a SIGNATURE: Leslie R. Miles, Jr. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2.1.62

22c. PHYSICIAN'S NAME (Type): Leslie R. Miles, Jr., M.D

22d. ADDRESS: Lonaconing, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 2/3/1962

23c. NAME OF CEMETERY OR CREMATORY: Memorial Park

23d. LOCATION (City, town or county) (State): Frostburg, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN ADDRESS: LONACONING, MD.

25a. REC'D BY REGISTRAR DATE: FEB 5 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kuna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01382 — 041965

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4, 15M 7 61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 54 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 146 FREDERICK STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CARL; Middle W; Last CORRICK

4. **DATE OF DEATH**: Month 2; Day 9; Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/11/05

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: ELECTRICL APPLIANCE

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: EDWARD CORRICK

14. MOTHER'S MAIDEN NAME: LUELLA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: CHART — Address

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Colon with
DUE TO (b): Generized metastisis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 1, 1962 to Feb 9, 1962 that (I) (we) last saw the deceased alive on Feb 7 1962 and that death occured at ....M, from the causes and on the date stated above.

22a. SIGNATURE: B. Mschindler M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/14/62

22c. PHYSICIAN'S NAME (Type): DR. B. SCHINDLER

22d. ADDRESS: 43 GREENE STREET

23a. BURIAL, CREMATION, REMOVAL* (Specify): Burial

23b. DATE THEREOF: 2/13/62

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.

23d. LOCATION (City, town or county) (State): Cumberland Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Louis Stein Inc.

ADDRESS: Cumb. Md

25a. REC'D BY REGISTRAR DATE FEB 13 '62

25b. REGISTRAR'S SIGNATURE: Clifford L. Travis

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AI5ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01383 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 01366

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 45 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 714 Brookfield Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lucy — Middle: Mae — Last: Cozad

4. DATE OF DEATH: Month: Feb. — Day: 10 — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 4, 1890

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Clothing Store

11. BIRTHPLACE (State or foreign country): Preston County, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: M. Judson Orr

14. MOTHER'S MAIDEN NAME: Alice Boogler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Anthony Cozad, Cumberland, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: suaden
420.1
DUE TO (b): Coronary Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Feb. 10, 1962

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, MD
Address (Street, city, town, or county): R9 Cumberland Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 13, 1962
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d. LOCATION (City, town, or country) (State): Cumberland, Md.

23. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. (Address)

24a. REC'D BY REGISTRAR: DATE FEB 14 '62

24b. REGISTRAR'S SIGNATURE: C. Thos L. Hearne

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01384

CERTIFICATE OF DEATH

01367

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 21 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MT. SAVAGE
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CHARLES — Middle — Last CUNNINGHAM

4. **DATE OF DEATH**: Month Feb. — Day 12 — Year 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: FEB. 28, 1893

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED**MT. SAVAGE REFACTORY

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): PA.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Thomas Cunningham

14. MOTHER'S MAIDEN NAME: Nora Kelley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220-10-0846

17. INFORMANT: PATIENTS CHART — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cancer of hepatic flexure Colon

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

153.1

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-6- 19 62, to 2-12- 19 62, that (I) (we) last saw the deceased alive on 2-11- 19 62, and that death occured at 2:06 AM, from the causes and on the date stated above.

22a. SIGNATURE: Lewis Brings M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-17-62

22c. PHYSICIAN'S NAME (Type): LEWIS BRINGS, M.D.

22d. ADDRESS: 59 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/15/62

23c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery

23d. LOCATION (City, town or county) (State): Mt. Savage, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Harvey A. Zeigler

ADDRESS: Hyndman, Pa.

25a. REC'D BY REGISTRAR DATE: FEB 16 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kuhn

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01385 01368

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 18 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 119 Wood St.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
d. STREET ADDRESS: 119 Wood St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Robinson — Last: Davis
4. DATE OF DEATH: Month: Feb. — Day: 10 — Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 1, 1889
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant
10b. KIND OF BUSINESS OR INDUSTRY: Grocery Stote
11. BIRTHPLACE (City or County & State, or foreign country): Mineral W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Jonathan W.W. Davis
14. MOTHER'S MAIDEN NAME: Florence I. Murphy
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Elton Gurley-Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Influenza — 3 Days
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Myocarditis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 10, 1961, to Feb 10, 1962, that (I) (we) last saw the deceased alive on Feb 10 1962, and that death occured at 1:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Paul R. Wilson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Feb 12, 1962
22c. PHYSICIAN'S NAME (Type): Paul R. Wilson
22d. ADDRESS: Piedmont, W.Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/14/62
23c. NAME OF CEMETERY OR CREMATORY: Philos
23d. LOCATION (City, town or county) (State): Westernport Md.

24 FUNERAL DIRECTOR'S SIGNATURE: E.L. Beal — ADDRESS: Westernport, Md.
25a. REC'D BY REGISTRAR DATE FEB 14 '62
25b. REGISTRAR'S SIGNATURE: Curtis S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01386 — 01369

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7,61

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: MARYLAND — 30 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 983 MCMULLEN HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MARY Middle: ADA Last: DAVIS

4. **DATE OF DEATH**: Month: FEB. Day: 28 Year: 19 62

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MARCH 2, 1882

9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRED GORTNER (DECEASED)

14. MOTHER'S MAIDEN NAME: LYDIA BEACHY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. **INFORMANT** Address: DAUGHTER: MILDRED DAVIS

18. **CAUSE OF DEATH** [Enter only one cause per line for (a) (b) and (c).]

MEDICAL CERTIFICATION

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction

DUE TO (b): Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: unk

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug ....., 1961, to 28 Feb, 1962 that (I) (~~we~~) last saw the deceased alive on 26 Jan 1962 and that death occured at ..... M, from the causes and on the date stated above

22a SIGNATURE: L Michael Glick M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/28/62

22c. PHYSICIAN'S NAME (Type): L. MICHAEL GLICK

22d. ADDRESS: 126 N SMALLWOOD CUMBERLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/2/62

23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK

23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: John J. Hafer

ADDRESS: 230 Baltimore Ave. Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE MAR 5 '62

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01387 **CERTIFICATE OF DEATH** 01390

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7 61

1. **PLACE OF DEATH**
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2126 Fredrick St. Cumberland, Md.
d. STREET ADDRESS: 126 Frederick St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Naomi Middle: I. Last: Davis

4. **DATE OF DEATH**: Month: Feb. Day: 11 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 13, 1896

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (County & State, or foreign country): Maryland Cumberland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Stephen Davis

14. MOTHER'S MAIDEN NAME: Ida Pyles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Pt.'s chart Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerosis Obstruction DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Mesenteric Thrombosis DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: 7 days / 7 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic + Hypertensive Cardiovascular Disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 26, 1961 to Feb 11, 1962, that (I) (we) last saw the deceased alive on 2/11/62, and that death occured at 4:26 PM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/13/62

22c. PHYSICIAN'S NAME (Type): Dr. Weisman

22d. ADDRESS: 57 Greene St Cumberland, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/15/62

23c. NAME OF CEMETERY OR CREMATORY: Emmanuel Meth. Cem.

23d. LOCATION (City, town or county) (State): Cumberland Md

24 FUNERAL DIRECTOR'S SIGNATURE: Davis Stein Inc. Cumb. Md

ADDRESS:

25a. REC'D BY REGISTRAR DATE: FEB 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01388 — 01371

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 9 HRS. 25 MIN
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA VALE, MARYLAND
d. STREET ADDRESS: 6 NATIONAL HIGHWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MARSHALL — Middle: J. — Last: DEREMER

4. DATE OF DEATH: Month: FEBRUARY — Day: 1 — Year: 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: MARCH 1, 1907

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRINTER

10b. KIND OF BUSINESS OR INDUSTRY: MONARCH PRINTING CO.

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: RANDOLPH DEREMER

14. MOTHER'S MAIDEN NAME: MAUDE E. BANE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 214-05-5331

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Possible Cerebro-vascular hemorrhage.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Chronic C.S.C.V. Disease Hypertension

DUE TO (c): Chronic Coronary Artery Disease.

INTERVAL BETWEEN ONSET AND DEATH: approx 20 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Apr 62, 19 62 to 2-1, 19 62, that (I) (we) last saw the deceased alive on 2-1, 19 62, and that death occured at 11:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John A Topper M.D.

22c. PHYSICIAN'S NAME (Type): DR. JOHN TOPPER

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: HYNDMAN, PA.

22b. DATE SIGNED: 2-5-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/4/62

23c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Burial Park

23d. LOCATION (City, town or county) (State): near Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: John J. Hafer, Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 5 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01389 **CERTIFICATE OF DEATH** 01372

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 7 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 121 HUMBIRD STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: James (James) Middle: E. (E. Dyche) Last: Dyche (Dyche)

4. **DATE OF DEATH**: Month: FEB. Day: 12 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 31, 1894

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): MAGNOLIA, W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES H. DYCHE

14. MOTHER'S MAIDEN NAME: JANE REXRODE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 705-09-9455

17. INFORMANT: MEMORIAL HOSPITAL, Address: CUMBERLAND, MD.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): T.T.C.
- DUE TO (b): Chronic Nephritis
- DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a): Papillary carcinoma bladder (under control)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 2-5- 19 62 to 2-12- 19 62 that (I) (we) last saw the deceased alive on 2-12- 19 62 and that death occured at 12 M. from the causes and on the date stated above.

22a. SIGNATURE: Howard K. Tolson

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Howard K. Tolson

M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 117-25 Center St. Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.15,1962

23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery

23d. LOCATION (City, town or county) (State): Cumberland,Md.

24. FUNERAL DIRECTOR'S SIGNATURE: James F. Scarpelli, Cumberland, Md.

ADDRESS

25a. REC'D BY REGISTRAR DATE FEB 15 '62

25b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01390 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 01373

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital D.O.A.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 1 318 Beall St.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Blanche — Middle: Amy — Last: Hager
4. DATE OF DEATH: Month: Feb. — Day: 8, — Year: 1962
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 14, 1899
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Fayette Co. Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Henry Solomon
14. MOTHER'S MAIDEN NAME: Susan King
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Joseph Hager — Address: 318 Beall St., Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): CORONARY SCLEROSIS
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: February 8, 1962
Address (Street, city, town, or county): R. 9, Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 11, 1962
22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial
22d. LOCATION (City, town, or country) (State): Cumberland, Md.

23. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.
24a. REC'D BY REGISTRAR — DATE: FEB 13 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01391 01374

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital, give street address): 221 N. Lee St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 221 N. Lee St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Anna; Middle: E.; Last: Heller

4. DATE OF DEATH: Month: Feb.; Day: 10; Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 9, 1878

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (County & State, or foreign country): Lonaconing, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Louis H. Fredericks

14. MOTHER'S MAIDEN NAME: Mary Anna Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.

17. INFORMANT: Miss Mildred M. Heller Address: 221 N. Lee St.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of Colon — 1 year
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from April, 19 62 to 6 Feb, 1962, that (I) (~~was~~) last saw the deceased alive on 6 Feb 1962 and that death occured at 11:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: L Michael Glick M.D.

22b. DATE SIGNED: 10 Feb 62

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): L. Michael Glick

22d. ADDRESS: 126 N. Smallwood St. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 2/13/62

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cem

23d. LOCATION (City, town or county) (State): Cumberland Md

24 FUNERAL DIRECTOR'S SIGNATURE: Lewis Stein Inc. ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62

25b. REGISTRAR'S SIGNATURE: Clifford L. Meese

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01392 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01375

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 624 Greene St.

2. USUAL RESIDENCE (Where deceased lived, If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 624 Greene St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James Middle: Smith Last: Helman
4. DATE OF DEATH: Month: February Day: 6 Year: 1962
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 20, 1884
9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant
10b. KIND OF BUSINESS OR INDUSTRY: Schmidt Bakery
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Joseph F. Helman
14. MOTHER'S MAIDEN NAME: Elizabeth Alsip
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Maude S. Helman, Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION, LEFT
DUE TO (b): CORONARY SCLEROSIS WITH THROMBOSIS
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: February 6, 1962
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
Address (Street, city, town, or county): R9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/8/62
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or country) (State): Cumberland, Md.

23. FUNERAL DIRECTOR: Louis Steck Jr.
ADDRESS: 117 Frederick St., Cumb. Md.
24a. REC'D BY REGISTRAR DATE: FEB 8 '62
24b. REGISTRAR'S SIGNATURE: C. Elmer L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01393 — 01376

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: MARYLAND 70 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Cumberland
d. STREET ADDRESS: 1011 Grant St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Eliza — Last: Houseworth

4. DATE OF DEATH: Month: Feb. — Day: 5 — Year: 1962

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 24, 1884
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Harpers Ferry, W. Va.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Cyrus H. Fisher
14. MOTHER'S MAIDEN NAME: Laura V. Barger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mrs. Howard Fisher, Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary Thrombosis & Infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

DUE TO (b): Arteriosclerosis — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 5, 1962 to Feb 5, 1962 that (I) (we) last saw the deceased alive on Feb 5 1962 and that death occured at 7:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/5/62
22c. PHYSICIAN'S NAME (Type): Dr. Clay E. Durrett, MD
22d. ADDRESS: 356 Virginia Ave. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 8, 1962
23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for our files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01394 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01377

1. PLACE OF DEATH
a. COUNTY: Allegany. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland Maryland.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: W.Va. b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Short Gap.
d. STREET ADDRESS: R5X
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CATHRYN — Middle — Last HUTTON

4. DATE OF DEATH: Month 2 — Day 8 — Year 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12 -25 -1897

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Williamsport , Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WARREN STOUCK.

14. MOTHER'S MAIDEN NAME: MARY ALICE Gilmore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 185-09-3887.

17. INFORMANT: Mr.Cyrus Calvin Hutton. — Address: Short Gap, W.Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): CORONARY SCLEROSIS
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): HYPERTENSIVE CARDIOVASCULAR DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county): R.9, Cumberland, Md.

DATE SIGNED: February 8, 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried.

22b. DATE THEREOF: 2/II/62

22c. NAME OF CEMETERY OR CREMATORY: Lahmansville Cemetery.

22d. LOCATION (City, town, or country) (State): Lahmansville, W.Va.

23. FUNERAL DIRECTOR: J.Blaine Schaeffer.

ADDRESS: Petersburg, W.Va.

24a. REC'D BY REGISTRAR DATE: FEB 13 '62

24b. REGISTRAR'S SIGNATURE: C. M. Turner

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01395 01378

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rurel Shaft Frostburg
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rurel Shaft Frostburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: T Last: Hyde

4. DATE OF DEATH: Month: February Day: 15 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 30, 1888

9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Barton, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred Hyde

14. MOTHER'S MAIDEN NAME: Mary Sugars

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Sherman Hyde "Son" Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Strangulation.
DUE TO (b): Asphyxiation
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 5 Min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of Item 18.): Hung self from ladder with dog chain

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year: Feb 15 1962

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Shop Building

20f. (City or town): Shaft (County): Allegany (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: W C McLane M.D.

ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type): W C McLane M.D.

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county): Frostburg Md.

DATE SIGNED: Feb 16 1962

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/18/62

22c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery

22d. LOCATION (City, town, or country): Moscow, (State): Md.

23. FUNERAL DIRECTOR: George Eichhorn ADDRESS: Lonaconing, Md.

24a. REC'D BY REGISTRAR DATE: FEB 19 '62

24b. REGISTRAR'S SIGNATURE: C Lee Fraser

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01396

CERTIFICATE OF DEATH

01379

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [redacted] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 8 HRS. 34 MIN.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 513 FREDERICK STREET
   a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: BABY — Middle: BOY — Last: JACOBS

4. **DATE OF DEATH**: Month: FEB. — Day: 13, — Year: 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-13-62

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 8 — Min.: 34

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: LEWIS F. JACOBS

14. MOTHER'S MAIDEN NAME: SANDRA LEE BROWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 771.5 Prematurity

DUE TO (b): Premature Rupture

DUE TO (c): membranes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 13 19 62 to 2:40 P.M. Feb 13 19 62 that (I) (we) last saw the deceased alive on Feb 13 19 62 and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: W. R. Hodges M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. W. ROYCE HODGES

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-15-1962

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 19 '62

25b. REGISTRAR'S SIGNATURE: Evelyn L. Krause

2 - 24161

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01397 — 01380

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): in auto enroute from his home to Dr.'s Office.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gilmore-R*F*D #1 Frostburg, MD.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: THOMAS — Middle: — Last: JOHNSON

4. DATE OF DEATH: Month: 2 — Day: 13 — Year: /1962 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/29/1880

9. AGE (In years last birthday): 81 yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Lonaconing, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Mose Johnson

14. MOTHER'S MAIDEN NAME: Barbara Cutter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. John Cutter, Lonaconing, MD. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Arteriosclerosis
DUE TO (c): Cerebral Hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (City or town) — (County) — (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 1, 19[illegible], to Feb. 3, 19[illegible], that (I) (we) last saw the deceased alive on Jan. 29, 19[illegible], and that death occured at [illegible] A.M., from the causes and on the date stated above.

22a. SIGNATURE: R W Reeves M D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): R.W.Reeves

22d. ADDRESS: Westernport, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/5/1962

23c. NAME OF CEMETERY OR CREMATORY: Old Coney Cemetery

23d. LOCATION (City, town or county): Lonaconing, MD. — (State)

24. FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN — ADDRESS: LONACONING, MD.

25a. REC'D BY REGISTRAR DATE: FEB 7 '62

25b. REGISTRAR'S SIGNATURE: Irving L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 7 61

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01398 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01381

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Allegany
   b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cumberland
   c. LENGTH OF STAY IN 1b: MARYLAND
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 107 N. Johnson St.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: 106 Massachusetts Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Franklin Kerns; Middle; Last

4. DATE OF DEATH: Month: February; Day: 23; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 18, 1908

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Pint Kerns

14. MOTHER'S MAIDEN NAME: Sarah Jane Robinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Mrs. William F. Kerns, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter on y one cause per l ne for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO
(b): Coronary Sclerosis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART I OTHER SIGNIF CANT CONDITIONS CONTRIBUT NG TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART 1.e)

420-1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW .NJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. .NJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER # ☐

Address (Street, city, town, or county): R 9 Cumberland

DATE SIGNED: 2/23/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/26/62

22c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Park

22d. LOCATION (City, town, or country) (State): Cumberland, Md.

23. FUNERAL DIRECTOR: Louis Steinke

ADDRESS: 117 Frederick St. Cumb., Md.

24a. REC'D BY REGISTRAR DATE: FEB 28 '62

24b. REGISTRAR'S SIGNATURE: C. Wm. L. Kerns

VS. A15ME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01399

CERTIFICATE OF DEATH

01382

1 PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg

c LENGTH OF STAY IN 1b:

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Miners Hospital, Frostburg, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Frostburg, M

d. STREET ADDRESS:

e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Casper — Middle: E — Last: Kight

4. DATE OF DEATH: Month: Feb. — Day: 23 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: Sept. 2, 1875

9 AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocery Store owner

10b. KIND OF BUSINESS OR INDUSTRY: own- retired

11. BIRTHPLACE (State or foreign country): W.Va.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Josh Kight

14. MOTHER'S MAIDEN NAME: Eliza Adams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16 SOCIAL SECURITY NO: 215-01- 8675

17 INFORMANT: Theodora Kight — Address: Frostburg, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 20 yrs.?

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): XXXX

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year: XXXX 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐: XXXX

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): XXXX

20f. (City or town) (County) (State): XXXX

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 2, 1962, to Feb. 23, 1962, that (I) (we) last saw the deceased alive on Feb. 23 1962, and that death occurred at 7:25 P.M. from the causes and on the date stated above

22a SIGNATURE: Martin M Rothstein M.D. — M.D — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b DATE SIGNED: 2/23/62

22c. PHYSICIAN'S NAME (Type): Martin M. Rothstein M.D.

22d. ADDRESS: 48 Broadway, Frostburg, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 2/26/62

23c. NAME OF CEMETERY OR CREMATORY: Philos Cemetery

23d LOCATION (City, town, or county) (State): Westernport Md.

24. FUNERAL DIRECTOR'S SIGNATURE: W.A. Fredlock Jr. — ADDRESS: Piedmont, W.Va.

25a. REC'D BY REGISTRAR DATE: FEB 26 '62

25b. REGISTRAR'S SIGNATURE: Irma L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rebuttal to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01400 — 01383

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   c. LENGTH OF STAY IN 1b: LIFE
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ROUTE 2

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   d. STREET ADDRESS: ROUTE 2 - CONSOLIDATION
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: HARRY — Middle: G. — Last: LEWIS

4. **DATE OF DEATH**: Month: FEBRUARY — Day: 16, — Year: 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 10, 1901

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JANITOR

10b. KIND OF BUSINESS OR INDUSTRY: BALLISTICS LAB.

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAVID G. LEWIS

14. MOTHER'S MAIDEN NAME: MARTHA JONES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-05-9859

17. **INFORMANT** Address: MRS. EMMA LEWIS, FROSTBURG, MD. BOX 58

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): [illegible] Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour

DUE TO (b): arteriosclerotic heart disease — 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3-2- ....., 19 60, to 2-16-, 19 62, that (I) (we) last saw the deceased alive on 2-4- 19 62, and that death occured at 6.4 M, from the causes and on the date stated above.

22a. SIGNATURE: Lewis Brings M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): LEWIS BRINGS, M. D. — 22d. ADDRESS: 57 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: FEB. 18 '62 — 23c. NAME OF CEMETERY OR CREMATORY: F'BG. MEMORIAL PARK — 23d. LOCATION (City, town or county) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: J. P. Ernst — ADDRESS: FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: FEB 19 '62 — 25b. REGISTRAR'S SIGNATURE: Anthony L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01401

CERTIFICATE OF DEATH

Reg. Dist. No. 01384

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 4mos.4days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sylvan Retreat

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 125 .. Jennie Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Leroy; Middle; Last Lowdermilk

4. DATE OF DEATH: Month February; Day 9; Year 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/29/85

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Interstate Commerce Inspector

10b. KIND OF BUSINESS OR INDUSTRY: B & O. Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lloyd Lowdermilk

14. MOTHER'S MAIDEN NAME: Sarah Riley

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 705-09-9855

17. INFORMANT: Mrs Leroy Lowdermilk — Address: Cumberland Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Pneumonia
DUE TO (b): Virus Infection, Respiratory
DUE TO (c): 17:11 Senility & Psychotic Reaction

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 5, 1961, to Feb. 9, 1962, that I last saw the deceased alive on Feb. 2, 1962, and that death occurred at 2:42 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. E. Mathews M.D.
ADDRESS (Street, city or town, state): 49 Greene St., Cumberland, Md.
DATE SIGNED

PHYSICIAN'S NAME (Type): L. E. Mathews, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/12/62
22c. NAME OF CEMETERY OR CREMATORY: Addison Cemetery
22d. LOCATION (City, town, or county) (State): Addison Pa

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Hafer
ADDRESS: Cumberland Md.

24a. REC'D BY REGISTRAR DATE: FEB 14 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01402 — 01385

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 6 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 11 ALTAMONT TERRACE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First DAVID — Middle THOMAS — Last MARTIN

4. **DATE OF DEATH**: Month FEBRUARY — Day 10 — Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-2-62

9. AGE (In years last birthday) IF UNDER 1 YEAR: 8 DAYS — Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None (Infant)

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): FROSTBURG, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN ROBERT MARTIN

14. MOTHER'S MAIDEN NAME: MARY NAIRN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No,

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MEMORIAL HOSPITAL-CUMBERLAND, MD.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Failure of Respiratory System	
DUE TO (b)	Intestinal obstruction	6 days
DUE TO (c)	Malrotation and mid gut volvulus	6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on ....., 19....., and that death occured at 9:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert W. Brodell M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/11/62

22c. PHYSICIAN'S NAME (Type): DR. ROBERT BRODELL

22d. ADDRESS: 129 S. LIBERTY ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/12/62 — 23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cem. — 23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Charles L. George Cumberland, Md. — 25a. REC'D BY REGISTRAR DATE FEB 13 '62 — 25b. REGISTRAR'S SIGNATURE: Carlton L. Thomas

VR A15 (4)
15M 7/61

216146 1.2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01403 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01386

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural of Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.A Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural of Cumberland X
d. STREET ADDRESS: 1 Cresaptown, Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Patrick — Last: McCusker

4. DATE OF DEATH: Month: February — Day: 1 — Year: 19 62

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/25/1903
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bus driver
10b. KIND OF BUSINESS OR INDUSTRY: Peoples Transit Co.
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William Oliver McCusker
14. MOTHER'S MAIDEN NAME: Carrie Jonetta Grant

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 214-07-6940
17. INFORMANT — Address: Elizabeth Richardson McCusker, Cresaptown, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): CORONARY SCLEROSIS

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Feb. 1, 1962 1962
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D. R9, Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/4/62
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
22d LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John J. Hafer, Cumberland, Maryland
24a. REC'D BY REGISTRAR — DATE: FEB 3 '62
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01404

CERTIFICATE OF DEATH

01387

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Lonaconing
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: George — Middle: — Last: McManus

4. DATE OF DEATH: Month: February — Day: 9 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March 4, 1879

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (County & State, or foreign country): Barton, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas McManus

14. MOTHER'S MAIDEN NAME: McCutcheon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: William A.Green — Address: Lonaconing, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocerditis and Myocerdial Degeneration Not Specified as Rheumatic — INTERVAL BETWEEN ONSET AND DEATH: 5 Years
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. [City or town] [County] [State]

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 10, 1961, to Feb. 9, 1962, that (I) (we) last saw the deceased alive on Feb. 2, 1962, and that death occured at 11.30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Paul R. Wilson M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: Feb 10 1962

22c. PHYSICIAN'S NAME (Type): Paul R. Wilson M.D.
22d. ADDRESS: Piedmont, W. Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/12/62
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City, town or county): Lonaconing, Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: George Eichhorn
ADDRESS: Lonaconing, Md.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

Items 21 & 4 — Item 9 Film G307 2/23/62 iwk 3/14/62 iwk

CERTIFICATE OF DEATH

Film G509

01388

01405

1. PLACE OF DEATH — a. COUNTY: Allegany — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg — c. LENGTH OF STAY IN 1b: MARYLAND, 1 Wk. — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Allegany — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Grahamtown — d. STREET ADDRESS: 77 Armstrong St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Ernest Middle Monsen Last

4. DATE OF DEATH: Month 2 Day 14 15 Year 1962

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: 8-26-1883 — 9. AGE (In years last birthday): 78 79/ yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist — 10b. KIND OF BUSINESS OR INDUSTRY: Railroad — 11. BIRTHPLACE (County & State, or foreign country): Oslo, Norway — 12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unknown — 14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No — 16. SOCIAL SECURITY NO: None — 17. INFORMANT Address: None — 77 Armstrong St. Grahamtown, Md. Miss Katherine G. Griffin, Sister-in-law

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirhosis of liver — weeks

DUE TO (b) Arteriosclerotic Cardiac disease — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/11/61 to 2/15/62 that (I) (we) last saw the deceased alive on 2/15/62 and that death occured at 1:15 P.M. from the causes and on the date stated above.

22a SIGNATURE: J B Davis, MD — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/16/62

22c PHYSICIAN'S NAME (Type): John B. Davis, MD — 22d ADDRESS: 2 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial — 23b DATE THEREOF: 2-18-62 — 23c. NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery — 23d. LOCATION (City, town or county) (State): Frostburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Pearl H. Mattingly — Hafer Funeral Home, Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: FEB 20 '62 — 25b. REGISTRAR'S SIGNATURE: Clinton S. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01406 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01389

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 55 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.L. Sacred Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 311 Broadway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: B. Last: Morris

4. DATE OF DEATH: Month: Feb. Day: 2 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 18, 1908

9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Car Inspector

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William W. Morris

14. MOTHER'S MAIDEN NAME: Julia F. Ryan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 705-96-9674

17. INFORMANT: Address: James E. Morris, Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Coronary Sclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I, or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic, MD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Benedict Skitarelic, MD

Address (Street, city, town, or county): R 9 Cumberland, Md.

DATE SIGNED: Feb. 2, 62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 2/5/62

22c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d. LOCATION (City, town, or country) (State): Cumberland, Md.

23. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli Cumberland, Md.

24a. REC'D BY REGISTRAR DATE: FEB 6 '62

24b. REGISTRAR'S SIGNATURE: Luther S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01407 **CERTIFICATE OF DEATH** 01390

Item 13-Film-G309 3/16/62 jnf

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 7 HR. 45 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: 931 GAY ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BABY — Middle: GIRL — Last: MULLENAX

4. DATE OF DEATH: Month: FEB. — Day: 17, — Year: 19 62

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-17-62

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 10 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MD.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM MULLENAX

14. MOTHER'S MAIDEN NAME: CATHERINE DEMPSIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 773.5 Respiratory Failure
DUE TO (b): Prematurity
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3:45 P.M. 19, that (I) (we) last saw the deceased alive on 19, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Robert H. Brodell M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. ROBERT D. BRODELL

22d. ADDRESS: 129 S. LIBERTY ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 2-17-62

23c. NAME OF CEMETERY OR CREMATORY: Memorial Hospital

23d. LOCATION (City, town or county) (State): Cumberland, Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE: Allegheny Soft Memorial Hosp

ADDRESS

25a. REC'D BY REGISTRAR DATE FEB 26 '62

25b. REGISTRAR'S SIGNATURE: Catherine L. Thomas

10L 395011

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01408

CERTIFICATE OF DEATH

01391

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH** — a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 55 MINUTES
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 419 BEALL ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: JOHN — Middle: — Last: PEDDER

4. **DATE OF DEATH**: Month: FEB. — Day: 15, — Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-17-1877

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chg. of Bleach Plt.

10b. KIND OF BUSINESS OR INDUSTRY: Paper Industry

11. BIRTHPLACE (County & State, or foreign country): ENGLAND, Widnes

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JAMES PEDDER

14. MOTHER'S MAIDEN NAME: SARAH Summersgill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 109-01-4649

17. INFORMANT — Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

DUE TO (b): Cirrhosis of Liver — 4 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9-6-58 9:35 P.M. to 2-15-62, 19..62 that (I) (we) last saw the deceased alive on 2-15-1962, and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: Ralph W. Ballin M.D. — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-17-62

22c. PHYSICIAN'S NAME (Type): DR. RALPH W. BALLIN

22d. ADDRESS: 62 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/18/62

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: H. Wayne George Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 20 '62

25b. REGISTRAR'S SIGNATURE: Curtis L. Krauss

VR A15 (4) 15M 7,61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01409 Item 8 Film 0307 2/16/62 ink 01352

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 21 HRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA VALE
   d. STREET ADDRESS: 35 RYE STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARL; Middle; Last PETERSON

4. DATE OF DEATH: Month FEBRUARY; Day 8; Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAY 31, 1879 (1880)

9. AGE (In years last birthday): 82 8X yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER (RET.)

10b. KIND OF BUSINESS OR INDUSTRY: OWN FARM

11. BIRTHPLACE (County & State, or foreign country): SWITZERLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PETER PETERSON

14. MOTHER'S MAIDEN NAME: SOPHIA HUSNED

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO

16. SOCIAL SECURITY NO.: 394 01 3075

17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Encephalomalacia right cerebrum

DUE TO (b): Arteriosclerosis, generalized, marked

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: (a) 1 wk (b) yrs (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on .....19....., and that death occured at 8:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lester Kiefer MD M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2/8/62

22c. PHYSICIAN'S NAME (Type): Lester Kiefer, MD

22d. ADDRESS: Memorial Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB. 12, 1962

23c. NAME OF CEMETERY OR CREMATORY: LINWOOD CEMETERY

23d. LOCATION (City, town or county) (State): DUBUQUE, IOWA

24 FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT

ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62

25b. REGISTRAR'S SIGNATURE: A. L. Evans

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01410 **CERTIFICATE OF DEATH** 01393

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN: MARYLAND 65 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 26 E. Roberts Street

2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland
d. STREET ADDRESS: 26 E. Roberts Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: Ann Last: Poole

4. DATE OF DEATH: Month: Feb. Day: 10 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Aug. 13, 1880

9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Hampshire County, W. Va

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Silas Iser

14. MOTHER'S MAIDEN NAME: Slemma Foltz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Mr. Ernest Poole, Flintstone, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease
DUE TO (c): (Multiple small stroke syndrome) — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year ---19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10-8-54 ..., 19..., to 2-8-62 ..., 19..., that (I) (we) last saw the deceased alive on 2-10-62 19..., and that death occured at 5:15 P.M., from the causes and on the date stated above.

22a. SIGNATURE: G. Himmelwright M.D.

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-13-62

22c. PHYSICIAN'S NAME (Type): G. Overton Himmelwright, M.D.

22d. ADDRESS: 133 Virginia Ave. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 14, 1962

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 15 '62

25b. REGISTRAR'S SIGNATURE: Emma L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01411 — 01394

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: MARYLAND — 1 DAY
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 207 DEXTER PLACE
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MARY — Middle ETTA — Last PRICE

4. **DATE OF DEATH**: Month FEB. — Day 1, — Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-4-1891

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife,

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA, Artemas

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: THOMAS LEASURE

14. MOTHER'S MAIDEN NAME: ANNABELL BARNES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No, (If yes give war or dates of service): ------

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MD. (Address)

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days
DUE TO (b): Arteriosclerosis, generalized — ?
DUE TO (c): Cardiac decompensation — 7 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan. 31, 1962 to Feb. 1, 1962 that (I) (we) last saw the deceased alive on 2/1/19 62, and that death occured at 7:13 P.M., from the causes and on the date stated above.

22a. SIGNATURE: George M. Simons M.D.

22b. DATE SIGNED: 2/2/62

22c. PHYSICIAN'S NAME (Type): DR. GEORGE M. SIMONS

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: ALGONQUIN HOTEL, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/3/62

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) (State): Cumberland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Charles L. George Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 5 '62

25b. REGISTRAR'S SIGNATURE: Clinton L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01412

CERTIFICATE OF DEATH

01395

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 7-61

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,
d. STREET ADDRESS: RT. #2, WILLIAMS ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER Middle R. Last REXROAD

4. DATE OF DEATH: Month FEBRUARY Day 17 Year 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JANUARY 27 1901

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CUMBERLAND CEMENT & SUPPLY

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN E. REXROAD

14. MOTHER'S MAIDEN NAME: REBECCA ROBISON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO

16. SOCIAL SECURITY NO.: 214-05-7279

17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma lung — INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from Dec ..... 19 61 to 2-17 ..., 19 62, that (I) (we) last saw the deceased alive on 2-17 ..... 19 62, and that death occured at 1:25 A.M. from the causes and on the date stated above.

22a. SIGNATURE: George M Simons M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DR. GEORGE M. SIMONS

22d. ADDRESS: ALGONQUIN HOTEL - CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/19/62

23c. NAME OF CEMETERY OR CREMATORY: Mt Herman Cemetery

23d. LOCATION (City, town or county) (State): Cumberland Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox

ADDRESS: Cumberland Maryland

25a. REC'D BY REGISTRAR DATE: FEB 21 '62

25b. REGISTRAR'S SIGNATURE: Clifton S Frana

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01413

CERTIFICATE OF DEATH

01396

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 16: 10/28/1955
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 622 Maryland Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Eva — Middle: — Last: Riehl

4. DATE OF DEATH: Month: February — Day: 3, — Year: 19 62

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6/21/1878

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired: Office

10b. KIND OF BUSINESS OR INDUSTRY: Swifts Meat Company

11. BIRTHPLACE (County & State, or foreign country): Cumberland, Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Jacob Riehl

14. MOTHER'S MAIDEN NAME: Christina Griesman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: P.O.Box 599 — Address: Cumberland,Md.
Allegany County Infirmary records.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial degeneration, Acute
DUE TO (b): Arterio-Sclerosis & Hypertension
DUE TO (c): Cerebral Hemorrhage

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/28/55, 19, to 2/3/62, 19, that (I) (we) last saw the deceased alive on 2/3/62, 19, and that death occured at @ 9:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒ — 22b. DATE SIGNED: 2/5/1962

22c. PHYSICIAN'S NAME (Type): Dr. Lee B. Mathews — 22d. ADDRESS: 49 Greene St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: FEB. 7, 1962 — 23c. NAME OF CEMETERY OR CREMATORY: TRINITY LUTHERAN CEMETERY — 23d. LOCATION (City, town or county) (State): CUMBERLAND, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: BYRON KIGHT — ADDRESS: CUMBERLAND, MD.

25a. REC'D BY REGISTRAR DATE: FEB 6 '62 — 25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7,61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01414 **CERTIFICATE OF DEATH** 01397

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7161

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 25 HRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: PENNSYLVANIA
   b. COUNTY: BEDFORD
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYNDMAN
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: DOVE Middle: E. Last: RITCHEY

4. **DATE OF DEATH**: Month: FEBRUARY Day: 6, Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEB. 28, 1894

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: B&O Railroad

11. BIRTHPLACE (County & State, or foreign country): Hyndman, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CLINTON RITCHEY

14. MOTHER'S MAIDEN NAME: MARY FERNER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 705-09-2589

17. INFORMANT: Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cholecystitis acute with Cholelithiasis — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

DUE TO (b): Pancreatitis acute hemorrhagic — 48 hours

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cholecystectomy Feb 5, 1962

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 5, 1962 to Feb 6, 1962 that (I) (we) last saw the deceased alive on Feb 6 1962 and that death occured at 8:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Wylie M Faw Jr Feb

22c. PHYSICIAN'S NAME (Type): DR. WYLIE M. FAW, JR. M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb 6 1962

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 9, 1962

23c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery

23d. LOCATION (City, town or county) (State): Hyndman, Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Teigler

ADDRESS: Hyndman, Pa.

25a. REC'D BY REGISTRAR DATE FEB 9 '62

25b. REGISTRAR'S SIGNATURE: Chas S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01415 — **CERTIFICATE OF DEATH** — 01398

Items 6 & 7, birth certif. in this Division 2/20/62.c.

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CUMBERLAND
d. STREET ADDRESS: RT. #4, BOX 65, OLDTOWN ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPH — Middle A. — Last RUPPENKAMP

4. DATE OF DEATH: Month FEBRUARY — Day 8 — Year 19 62

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	10-9-1903	58 59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED MECH. HELPERB. & O. R.R.CO.		CUMBERLAND, MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOSEPH RUPPENKAMP	SOPHIA BRINKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	217-10-1615	MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Oropageal Varies with Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): A.S tent duoon with terminal Congestive Failure — 1 week
DUE TO (c): Cirhosis Liver, Laennec's type, — 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a): Hem. arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ / Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Feb., 19 62 to 8 Feb., 19 62 that (I) (we) last saw the deceased alive on 8 Feb., 19 62 and that death occured at 11:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. Alfred Van Ormer, M.D — ATTENDING PHYS. ☒ / MED. DIRECTOR ☐ / STAFF PHYS. ☐ — 22b. DATE SIGNED: 10 Feb 62

22c. PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER — 22d. ADDRESS: 122 S. CENTRE STREET, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	Feb.12,1962	St. Mary's Cemetery	Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	FEB 14 '62	Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part [redacted] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely [redacted]ed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01415 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01399

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 68 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 46 Utah Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carl — Middle: Henry — Last: Schade

4. DATE OF DEATH: Month: Feb. — Day: 23 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 25, 1893

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction Co.

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carl H. Schade

14. MOTHER'S MAIDEN NAME: Anna B. Hahn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): War I
(If yes give war or dates of service): yes

16. SOCIAL SECURITY NO.: 214-05-6428

17. INFORMANT: Address: Mr. Arthur E. Schade, Cumberland, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE
DUE TO (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE ---
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: " 2 Hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Feb. 23, 1962

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

Address (Street, city, town, or county): Cumberland Md (State)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb. 26, 1962

22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

22d. LOCATION (City, town, or county): Cumbrland, Md.

23. FUNERAL DIRECTOR: ADDRESS: James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR: DATE: MAR 1 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01417 — 01460

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 15M 7/61

1. **PLACE OF DEATH** — a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 3 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   d. STREET ADDRESS: 29 ELDER ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ROBERT — Middle: L. — Last: SETTLE

4. **DATE OF DEATH**: Month: FEB. — Day: 19 — Year: 19 62

5. SEX: M

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/6/93

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carman

10b. KIND OF BUSINESS OR INDUSTRY: Raliroad

11. BIRTHPLACE (County & State, or foreign country): VIRGINIA Rappahanock

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ASHBY SETTLE

14. MOTHER'S MAIDEN NAME: LUCY SETTLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis c Infarction — INTERVAL BETWEEN ONSET AND DEATH: Acute

DUE TO (b): Myocarditis c Decompensation — 2 yrs

DUE TO (c): Arteriosclerosis — 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 9; 15 58 AM to Jul 19, 1962 that (I) (we) last saw the deceased alive on Jul. 19 1962, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Clay E. Durrett M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/20/62

22c. PHYSICIAN'S NAME (Type): DR. CLAY DURRETT

22d. ADDRESS: 236 VIRGINIA AVE. CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-22-62

23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James F. Scarpelli Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 26 '62

25b. REGISTRAR'S SIGNATURE: Clay E. Durrett

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01418

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01401

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b: 40 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 320 Bedford Street

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
d. STREET ADDRESS: 320 Bedford Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Blaine — Last: Shewbridge

4. DATE OF DEATH: Month: February — Day: 22 — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 26, 1884

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Celanese Employee

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Shewbridge

14. MOTHER'S MAIDEN NAME: Mary Finn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-10-5666

17. INFORMANT: Mrs. Bessie Shewbridge
Address: 320 Bedford Street, Cumberland, Maryland

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION
DUE TO (b): CORONARY SCLEROSIS
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4201

INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: Feb. 22, 1962

Address (Street, city, town, or county): Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/25/62

22c. NAME OF CEMETERY OR CREMATORY: Mt Herman Cemetery

22d. LOCATION (City, town, or country): Cumberland (State): Maryland

23. FUNERAL DIRECTOR: Ruth E. Silcox

ADDRESS: Cumberland Maryland

24a. REC'D BY REGISTRAR DATE: FEB 26 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01419

CERTIFICATE OF DEATH

01402

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Parts 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Parts 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7 61

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 5 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If Institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND Rt #1
d. STREET ADDRESS: BOWMAN'S ADDITION
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDMOND Middle Last SHIPLEY

4. DATE OF DEATH: Month FEBRUARY Day 17 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY 31, 1884

9. AGE (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired B & O Employee

10b. KIND OF BUSINESS OR INDUSTRY: Maintenance Dept

11. BIRTHPLACE (County & State, or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DOSH SHIPLEY

14. MOTHER'S MAIDEN NAME: MARTHA GRIMM

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 219-03-9507

17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Chronic Glomerulonephritis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-14-62, 19 62 to 12-17-62, 19 62, that (I) (we) last saw the deceased alive on 12-17-62 19 62 and that death occurred at 10:45 AM from the causes and on the date stated above.

22a. SIGNATURE: James G. Stegmaier M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): JAMES G. STEGMAIER

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/20/62

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county): Cumberland (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Ruth E. Silcox ADDRESS: Cumberland Maryland

25a. REC'D BY REGISTRAR DATE FEB 23 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 7.61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01420

CERTIFICATE OF DEATH

01403

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN Ib: 7 HRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
d. STREET ADDRESS: 108 W. MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First WILLIAM — Middle W. — Last SLUSS

4. **DATE OF DEATH**: Month FEB. — Day 24, — Year 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: MAR. 30, 1878

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED GROCER

10b. KIND OF BUSINESS OR INDUSTRY: OWN STORE

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS SLUSS

14. MOTHER'S MAIDEN NAME: ANNA M. SHULTZER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)

16. SOCIAL SECURITY NO.: 214-32-3507

17. INFORMANT: WM. W. SLUSS, JR. — Address: FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cerebrovascular Disease
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) X

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year: X, 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 22, 19 62 to 2/24, 19 62, that (I) (we) last saw the deceased alive on 2/24 19 62, and that death occured at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Martin Rothstein, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/26/62

22c. PHYSICIAN'S NAME (Type): MARTIN ROTHSTEIN, M. D.

22d. ADDRESS: 48 BROADWAY, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB. 27 '62

23c. NAME OF CEMETERY OR CREMATORY: F'BG. MEMORIAL PARK

23d. LOCATION (City, town or county) (State): FROSTBURG, MD.

24. FUNERAL DIRECTOR'S SIGNATURE: J. K. Durst

ADDRESS: FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: MAR 1 '62

25b. REGISTRAR'S SIGNATURE: Esther S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01421 Item 8 Film G308 3/5/62 jwk

01404

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN this place: 26 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND 02
d. STREET ADDRESS: 100 NEW HAMPSHIRE AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARGARET Middle: M. Last: SPRING

4. DATE OF DEATH: Month: FEB. Day: 21 Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 5/31/1887 1886

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CLERK

10b. KIND OF BUSINESS OR INDUSTRY: GOVERNMENT

11. BIRTHPLACE (County & State, or foreign country): MARYLAND -HANCOCK,

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: DECEASED Jacob F. Mouse

14. MOTHER'S MAIDEN NAME: DECEASED Loretta Ortman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: CHART
Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure

DUE TO (b): Arteriosclerotic Cardiovascular Disease

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 26 days / 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/4 1962, to 2/21, 1962, that (I) (we) last saw the deceased alive on 2/21 1962 and that death occured at 7:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 2/23/62

22c. PHYSICIAN'S NAME (Type): S. G. Weisman

22d. ADDRESS: 59 Greene St Cumberland Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 24, 1962

23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul Cemetery

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: James F. Scarpelli, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 27 '62

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01422

CERTIFICATE OF DEATH

Item 8 Film G207 2/23/62 iwk

01405

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg
c. LENGTH OF STAY IN 1b: 5 minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miners Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eckhart, Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ORVILLE Middle G. Last STEELE

4. DATE OF DEATH: Month 2 Day 14 Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-24-1962/ 1902

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mines

11. BIRTHPLACE (County & State, or foreign country): Zihlman, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Steele

14. MOTHER'S MAIDEN NAME: Daisy Mustetter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 213-09-6546

17. INFORMANT: Mrs. Myrtle Steele, Eckhart, Md.
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Rt. Lung
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 6 months +

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from Summer ....., 19 61, to February ....., 19 62, that (I) (we) last saw the deceased alive on Feb. 1 ..... 19 62, and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: Calvin Y. Hadidian M.D.

22b. DATE SIGNED: 2/15/62

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): CALVIN Y. HADIDIAN

22d. ADDRESS: ALGONQUIN HOTEL, Cumberland

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/18/62

23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park

23d. LOCATION (City, town or county): Frostburg (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Beulah H. Montesmit
ADDRESS: Hafer Funeral Home 23 E. Main, Frostburg, Md.

25a. REC'D BY REGISTRAR DATE: FEB 20 '62

25b. REGISTRAR'S SIGNATURE: C. Elmer S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01423

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01408

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1. PLACE OF DEATH
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 2 Hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
   d. STREET ADDRESS: 236 E. MAIN STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALLEN Middle: HARRISON Last: STEWART

4. DATE OF DEATH: Month: FEBRUARY Day: 27TH, Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED XX DIVORCED ☐

8. DATE OF BIRTH: NOV. 27TH, 1888

9. AGE (In years last birthday): 73 Yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET.-CONDUCTOR

10b. KIND OF BUSINESS OR INDUSTRY: RAILROADING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN STEWART

14. MOTHER'S MAIDEN NAME: ANNA MARY PENGELLY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO: 712-14-1585

17. INFORMANT: MRS. DOROTHY V. CLOSE, 236 E. MAIN STREET, FROSTBURG, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO (b): CORONARY SCLEROSIS

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): APLASTIC ANEMIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: FEBRUARY 27, 1962

Address (Street, city, town, or county): Cumberland, Md. (State)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-2-62

22c. NAME OF CEMETERY OR CREMATORY: ECKHART CEMETERY

22d. LOCATION (City, town, or country): ECKHART, MD.

23. FUNERAL DIRECTOR: J. R. Lucas

ADDRESS: FROSTBURG, MD.

24a. REC'D BY REGISTRAR DATE MAR 5 '62

24b. REGISTRAR'S SIGNATURE: Emma L. Mann

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01424 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01407

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 106 Hanover Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland, Maryland
d. STREET ADDRESS: 106 Hanover Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Robert Middle: Benedict Last: Sturtz
4. DATE OF DEATH: Month: Feb Day: 7, Year: 19 62
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/18/1897
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR Months Days: IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mt. Savage, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Simon P. Sturtz
14. MOTHER'S MAIDEN NAME: Clara Dickel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): W. War I
16. SOCIAL SECURITY NO.: 213-22-3198
17. INFORMANT: Address: Mrs. Mary Sturtz 106 Hanover St. Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

CORONARY SCLEROSIS WITH THROMBOSIS

INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒, and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: February 7, 1962
Address (Street, city, town, or county): R9 Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/10/62
22c. NAME OF CEMETERY OR CREMATORY: St. Patricks Catholic Cem.
22d. LOCATION (City, town, or country) (State): Cumberland, Maryland
23. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland Maryland
24a. REC'D BY REGISTRAR DATE: FEB 13 '62
24b. REGISTRAR'S SIGNATURE: Elton L. Kratz

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01425 — 01408

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 849 Mt Royal Ave.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 Cumberland, MD
d. STREET ADDRESS: 849 Mt Royal Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: Frances Last: Summers

4. DATE OF DEATH: Month: Feb. Day: 4 Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Jan 29 1919

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR — Months: Days: IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Time Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Kelly Springfield Tire Co.

11. BIRTHPLACE (County & State, or foreign country): Chicago Ill.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William M. Ratchey

14. MOTHER'S MAIDEN NAME: Marie Twigg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service): No

16. SOCIAL SECURITY NO.: 229-46-2382

17. INFORMANT: Turner T. Summers Cumb. Md
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 4 I C X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Terminal Cardiac arrest
DUE TO (c): Chronic valvular heart disease, mitral insufficiency, and congestive failure

INTERVAL BETWEEN ONSET AND DEATH: 20 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatic fever, 1955, history of

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1960 to 4 Feb., 1962 that (I) saw last saw the deceased alive on 31 Dec 1961, and that death occured at 6 PM, from the causes and on the date stated above.

22a. SIGNATURE: W. Alfred Van Ormer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5 Feb. 62

22c. PHYSICIAN'S NAME (Type): W. Alfred Van Ormer, M. D.

22d. ADDRESS: 122 S. Centre Street, Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/8/62

23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cem.

23d. LOCATION (City, town or county) (State): Cumberland Md

24 FUNERAL DIRECTOR'S SIGNATURE: Ramsburg Inc.
ADDRESS: Cumb. Md.

25a. REC'D BY REGISTRAR DATE: FEB 7 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Ramsburg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01426

CERTIFICATE OF DEATH

01409

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4
15M 7/61

1. PLACE OF DEATH
a. COUNTY: ALLEGANY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 3HRS. 25 MIN.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
d. STREET ADDRESS: RT. #3, BEDFORD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LESTER; Middle: ; Last: TEWELL

4. DATE OF DEATH: Month: FEB. Day: 7, Year: 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-18-1894

9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Driver

10b. KIND OF BUSINESS OR INDUSTRY: Oil Company

11. BIRTHPLACE (County & State, or foreign country): ARTEMAS, PA.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: WILLIAM TEWELL

14. MOTHER'S MAIDEN NAME: HARRIETT SHIPLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO

16. SOCIAL SECURITY NO. (If yes give wer or dates of service): 214 07 1277

17. INFORMANT: Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

DUE TO (b): Coronary Artery Disease, advanced

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from July 8:25 P.M. 1968 to Feb. 7 1962 that (I) (we) last saw the deceased alive on Feb. 7 1962 and that death occured at . M. from the causes and on the date stated above.

22a. SIGNATURE: William P James M D

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/2/62

22c. PHYSICIAN'S NAME (Type): DR. WILLIAM P. IAMES

22d. ADDRESS: 411 N. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb.11,1962

23c. NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Byron Kight

ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62

25b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01427 — 01410

1. PLACE OF DEATH
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
c. LENGTH OF STAY IN 1b: 12 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SACRED HEART HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY: Mineral
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R.D. (P.O. Kitzmiller, Md.) RFX-3
d. STREET ADDRESS: Potomac Manor, W.Va.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HELEN — Middle: M — Last: TRANUM

4. DATE OF DEATH: Month: 2 — Day: 25 — Year: 19 62

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 11/29/62 (90)

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Theodore Spiker

14. MOTHER'S MAIDEN NAME: Anna Duckworth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 213-01-6603B

17. INFORMANT: CHART - Mrs. Delbert Michaels, Cumberland, Md.
Address: R.D.5

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible]
DUE TO (b): [illegible]
DUE TO (c): [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: [illegible]

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/20, 1962 to 2-25, 1962, that (I) (we) last saw the deceased alive on 2-25, 19 62, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/26/62

22c. PHYSICIAN'S NAME (Type): DR. B.M.SCHINDLER

22d. ADDRESS: 206 GREENE STREET

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/27/62

23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F.Cemetery

23d. LOCATION (City, town or county) (State): Elk Garden, W.Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Amy Mildred Sharpless
ADDRESS: Blaire, W.Va.

25a. REC'D BY REGISTRAR DATE: MAR 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kuntz

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
TSM 7,61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01428 — 01411

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1. **PLACE OF DEATH**
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROUTE 1, FROSTBURG
c. LENGTH OF STAY IN 1b: 50 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROUTE 1, FROSTBURG
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First WILLIAM Middle L. Last WALKER

4. **DATE OF DEATH**: Month FEBRUARY Day 18TH Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 27TH, 1878

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET.*CUSTODIAN

10b. KIND OF BUSINESS OR INDUSTRY: COUNTY BLDG.

11. BIRTHPLACE (County & State, or foreign country): SCOTLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM WALKER

14. MOTHER'S MAIDEN NAME: AGNES SPEIR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO. 220-10-9346

17. **INFORMANT** Address: MRS. EDITH A. WALKER, RT. 1, FROSTBURG, MD.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage

DUE TO (b) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: 6 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb 15, 1962 to Feb 18, 1962, that (I) (we) last saw the deceased alive on Feb 18, 1962, and that death occured at 4:15 M, from the causes and on the date stated above.

22a. SIGNATURE: W. O. McLane, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-19-62

22c. PHYSICIAN'S NAME (Type): W. O. McLANE,

22d. ADDRESS: 167 E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-21-62

23c. NAME OF CEMETERY OR CREMATORY: F'BG. MEMORIAL PARK

23d. LOCATION (City, town or county): FROSTBURG, (State) MD.

24 FUNERAL DIRECTOR'S SIGNATURE: J. L. Durst,

ADDRESS: FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: FEB 23 '62

25b. REGISTRAR'S SIGNATURE: Irving S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01429 01412

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The ■ please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7 61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 20 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CORRIGANVILLE
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CLARA A. Middle Last WALTERS

4. **DATE OF DEATH**: Month FEBRUARY Day 5 Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPT. 21, 1897

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Celanese, Kelly-Springfield Factory

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): CUMBERLAND, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HARRY WALTERS George Park

14. MOTHER'S MAIDEN NAME: IDA COOLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 230-24-0195

17. INFORMANT: MEMORIAL HOSPITAL, Address: CUMBERLAND, MD.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Senear-Usher Syndrome	6 mo
DUE TO (b)	Lobular Pneumonia	2 weeks
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURED. Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12 Dec, 1961, to 4 Feb, 1962, that (I) (we) last saw the deceased alive on 4 Feb 1962, and that death occured 8:30 AM from the causes and on the date stated above.

5 FEB 1962

22a SIGNATURE: Mark M. Kroll

22b DATE SIGNED

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): MARK M. KROLL

22d. ADDRESS: 110 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb. 8, 1962

23c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Memorial Gardens

23d. LOCATION (City, town or county) (State): Cumberland, Md. RD

24. FUNERAL DIRECTOR'S SIGNATURE: Harvey H. Zeigler

ADDRESS: Hyndman, Pa.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62

25b REGISTRAR'S SIGNATURE: Clifton S. Piano

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01413

01430

1. **PLACE OF DEATH** a. COUNTY: ALLEGANY — b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CUMBERLAND — c. LENGTH OF STAY IN 1b: MARYLAND — d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SACRED HEART HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission) a. STATE: MARYLAND — b. COUNTY: ALLEGANY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CRESAPTOWN, Rt. # 5 Cumb. Md. — d. STREET ADDRESS: 123 Meadow Drive — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ETHEL — Middle: MAE — Last: WENRICH

4. DATE OF DEATH: Month: FEB — Day: 24 — Year: 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 11, 1903

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Ridgeley, W. Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oliver W. Summers

14. MOTHER'S MAIDEN NAME: Amanda R. Dixon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Joseph G. Wenrich — Address: 123 Meadow Drive Cresaptown, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 4 2 0.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 15, 19 61 to Feb. 24, 19 62 that (I) (we) last saw the deceased alive on Feb. 23 19 62, and that death occured at ..... M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] — ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/26/62

22c. PHYSICIANS NAME (Type): DR. B. M SCHINDLER

22d. ADDRESS: XXX GREENE STREET

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/27/62

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

23d. LOCATION (City, town or county) (State): Cumberland, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: H. Wayne George, Cumberland, Md.

25a. REC'D BY REGISTRAR DATE: FEB 28 '62

25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01431 01414

1. PLACE OF DEATH
a. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westernport
c. LENGTH OF STAY IN 1b: 20 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 201 Rock
MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Westernport
d. STREET ADDRESS: 201 Rock
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Howard; Middle: Ervin; Last: Whisner

4. DATE OF DEATH: Month: Feb. Day: 27 Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 13, 1892

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (City or County & State, or foreign country): Mineral W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Whiner

14. MOTHER'S MAIDEN NAME: Isadora Morningstar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 236-03-3866

17. INFORMANT: Carl Whisner-Bloomington, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: One Hour
DUE TO (b): Arterio-sclerosis with Hypertension — Ten Years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. [City or town] (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 10, 1953 to Feb. 27, 1962, that (I) (we) last saw the deceased alive on Feb. 10 1962, and that death occured at 7:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Paul R Wilson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb. 28, 1962

22c. PHYSICIAN'S NAME (Type): Paul R. Wilson

22d ADDRESS: Piedmont, W.Va.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/1/62

23c. NAME OF CEMETERY OR CREMATORY: Philos

23d. LOCATION (City, town or county): Westernport (State): Md.

24 FUNERAL DIRECTOR'S SIGNATURE. [signature]

ADDRESS: Westernport, Md.

25a REC'D BY REGISTRAR DATE MAR 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [redacted] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01432 — Reg. Dist. No. 01415

1. PLACE OF DEATH
a. COUNTY: Allegany — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 716 N. Centre St.,

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland — b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland,
d. STREET ADDRESS: 716 N. Centre St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Francis — Last: Wigger

4. DATE OF DEATH: Month: Feb. — Day: 24, — Year: 19 62

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 23, 1903

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Deliveryman

10b. KIND OF BUSINESS OR INDUSTRY: Brewery

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James B. Wigger

14. MOTHER'S MAIDEN NAME: May Shank

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No, (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 214-05-5015

17. INFORMANT: Mrs. Leona Wigger — Address: 716 N. Centre St., Cumb. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cerebral Cervical Glands — INTERVAL BETWEEN ONSET AND DEATH:

178.9

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b): General Melanosis

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.): X

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19: X

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/9/46, 19—, to 2/24, 1962, that I last saw the deceased alive on 2/24/62, 19—, and that death occurred at 1:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. B. Mathews M.D. — M.D.

PHYSICIAN'S NAME (Type): L. B. Mathews M.D. — ADDRESS (Street, city or town, state): 49 Greene St Cumberland Md — DATE SIGNED: 2/26/62

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/27/62

22c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

22d. LOCATION (City, town, or county) (State): Cumberland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: H. Wayne George — ADDRESS: Cumberland, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 28 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01433

CERTIFICATE OF DEATH

01416

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4
15M 7 61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 9 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X LONACONING
   d. STREET ADDRESS: DOUGLAS AVE., BOX 106
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): FRANCIS (First) C. (Middle) WILHELM (Last)

4. **DATE OF DEATH**: FEB. 8, (Month, Day) 1962 (Year)

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-8-1885

9. AGE (In years last birthday): 76 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: OLIN WILHELM

14. MOTHER'S MAIDEN NAME: CATHERINE GARLITZ

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 219-03-8049

17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MD. Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Congestive heart failure

DUE TO (b): Hypertensive and arteriosclerotic cardio-vas. Dis. 5 years ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hyp. arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 1 mo. 2:20 P.M. to 8 Feb., 1962, that (I) (we) last saw the deceased alive on 8 Feb. 1962 and that death occured at ....M, from the causes and on the date stated above.

22a. SIGNATURE: W. Alfred Van Ormer M.D.

22b. DATE SIGNED: 10 Feb 62

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): DR. W. A. VAN ORMER

22d. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/11/1962

23c. NAME OF CEMETERY OR CREMATORY: St. Anns Cemetery

23d. LOCATION (City, town or county) (State): Avilton, MD. (Garrett, CO.

24 FUNERAL DIRECTOR'S SIGNATURE: GEORGE EICHHORN ADDRESS: LONACONING, MD.

25a. REC'D BY REGISTRAR DATE: FEB 13 '62

25b. REGISTRAR'S SIGNATURE: Irving L. Nuss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01434

CERTIFICATE OF DEATH

01417

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [redacted] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: ALLEGANY — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   c. LENGTH OF STAY IN 1b: 28 DAYS
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MEMORIAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution, Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: ALLEGANY
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 02 CUMBERLAND
   d. STREET ADDRESS: 304 COLUMBIA STREET
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First LOTTIE — Middle L. — Last WILLIAMSON

4. **DATE OF DEATH**: Month FEBRUARY — Day 24 — Year 1962

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 3, 1893

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): LEVELS, W.VA.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: FRANK SHANHOLTZER

14. MOTHER'S MAIDEN NAME: ALMETA DURST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Breast with Metastasis — INTERVAL BETWEEN ONSET AND DEATH: Oct 1961

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1955, 19..., to Feb 62, 19..., that (I) (we) last saw the deceased alive on Feb 23 1962 and that death occured 12:35 PM from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/27/62

22c. PHYSICIAN'S NAME (Type): G. OVERTON HIMMELWRIGHT

22d. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/27/62

23c. NAME OF CEMETERY OR CREMATORY: Levels Cemetery

23d. LOCATION (City, town or county) (State): Levels, W. Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Byron Kight — ADDRESS: Cumberland, Md.

25a. REC'D BY REGISTRAR — DATE MAR 1 '62

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01435 — 01418

1. **PLACE OF DEATH**
a. COUNTY: ALLEGANY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FROSTBURG
c. LENGTH OF STAY IN 1b: 3 WKS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MINERS HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X MT. SAVAGE
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First WILLIAM — Middle B. — Last WINEBRENNER

4. **DATE OF DEATH**: Month FEBRUARY — Day 2nd, — Year 19 62

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: AUG. 28th, 1903

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BRICK SETTER

10b. KIND OF BUSINESS OR INDUSTRY: BRICK PLANT

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: WILLIAM M. WINEBRENNER

14. MOTHER'S MAIDEN NAME: SUSAN WHETZEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)

16. SOCIAL SECURITY NO. (If yes give wer or dates of service): 214-01-0111

17. INFORMANT — Address: MRS. JOHN EVANS, MIDLOTHIAN, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cerebralvascular hemorrhage — 3 wks

DUE TO (c): Arteriosclerosis — years

331A

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan, 1962 to Feb. 2, 1962, that (I) (we) last saw the deceased alive on Feb. 1 1962, and that death occured at 9 AM, from the causes and on the date stated above.

22a. SIGNATURE: Leslie R. Miles M.D. M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): LESLIE R. MILES, M

22d. ADDRESS: E. MAIN ST., LONACONING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-5-62

23c. NAME OF CEMETERY OR CREMATORY: METHODIST CEMETERY

23d. LOCATION (City, town or county) (State): MT. SAVAGE, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: J. P. Durst

ADDRESS: FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE FEB 5 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Items 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61